DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 7

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/02

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ Budget neutral
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 1 through ~~5.5~~ 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 1 through ~~5.6~~ 6

10. SUBJECT OF AMENDMENT:
PAYMENT TO NON-INSTITUTIONAL PROVIDERS OF MEDICAL CARE

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Patricia Murakami

13. TYPED NAME:
Patricia Murakami

14. TITLE:
Acting Director

15. DATE SUBMITTED:
12/27/02

16. RETURN TO:
STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
P. O. BOX 700190
KAPOLEI, HI 96709-0190

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/30/02

18. DATE APPROVED:
March 2, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/02

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Hea

23. REMARKS:
Modified blocks 8 and 9 by request of State staff.

State:	HAWAII

NONINSTITUTIONAL ITEMS AND SERVICES:

Payment to providers of medical care who are individual practitioners, including doctors of medicine, dentists, podiatrists, psychologists, osteopaths, optometrists, and other individuals providing services, shall be based upon the Hawaii Medicaid fee schedule.

1. HAWAII MEDICAID FEE SCHEDULE:

Hawaii Medicaid will not pay more than the billed amount or the maximum allowed by Federal law and regulation. Moreover, rates are established in accordance with the provisions of the Appropriation Act and other applicable State statutes.

The State assures that the fee schedules rates for public and private providers of Medicaid services, products or items are the same and the State does not subdivide or subclassify its payment rates based on whether the provider is a public or private entity/provider, except for payment of services provided by a resident physician in a teaching facility when payments are lower than the fee schedule. Annual or periodic adjustments will be made and that such adjustments will be reflected in the fee schedule that is made available to the providers and the public.

Payment for noninstitutional items and services, with the exception of prescribed drugs, DME, medical supplies, dental services, home pharmacy services, and EPSDT services, shall be based on the Hawaii Medicaid fee schedule. The Hawaii Medicaid fee schedule is generally based on varying percentages of the Medicare fee schedule for providers's who participate in Medicare. These services include, but are not limited to:

(a) Physician services;

(b) Podiatric services;

(c) Optometric services;

(d) Other practitioner services including nurse midwife, pediatric nurse practitioner, advanced practice registered nurse in behavioral health, and licensed social worker in behavioral health;

(e) Physical therapy;

(f) Occupational therapy;

(g) Services for persons with speech, language, and hearing disorders;

(h) Sleep services; and

(i) Other services specified by the Department.

2. MEDICAID PAYMENTS FOR OTHER NONINSTITUTIONAL ITEMS AND SERVICES ARE DETERMINED AS FOLLOWS:

The State assures that the fee schedules rates for public and private providers of Medicaid services, products or items are the same and the State does not subdivide or subclassify its payment rates based on whether the provider is a public or private entity/provider, except for payment of services provided by a resident physician in a teaching facility when payments are lower than the fee schedule. Annual or periodic adjustments will be made and that such adjustments will be reflected in the fee schedule that is made available to the providers and the public.

(a) The following items and services are limited to billed charges, not to exceed the Medicare fee schedule for providers who participate in Medicare or the rate established by the Department:

- Durable Medical Equipment (including eyeglass frames and hearing aids), prosthetic devices and appliances except, that Intraocular lens, cochlear implants, and neurostimulators are provided as part of an outpatient surgical procedure and are limited to invoice cost, not to exceed the Medicare fee schedule for the surgical service.
- Dental services (including dentures);
- EPSDT (comprehensive periodic examination, case management, skilled nursing and personal care services.)
- Home pharmacy services;
- Medical supplies;
- Home Health Agency Services

(b) Payment for laboratory services and X-ray services shall not exceed the current Medicare fee schedule for participating providers.

(c) Payments for outpatient hospital treatment room services shall not exceed the lowest of:

1. The rate established by the Department;

2. Seventy-five percent of billed charges; or

3. The Medicare fee schedule for providers who participate in Medicare.

(d) Payments for an emergency room shall not exceed the lowest of the rate established by the department, seventy-five per cent of billed charges, or the Medicare fee schedule for providers who participate in Medicare.

(e) Payments for lenses for eyeglasses shall be limited to the lower of billed charges, not to exceed the lower of the cost plus ten per cent or the Medicare fee schedule for providers who participate in Medicare.

(f) Payments for hearing devices shall be the actual claim charge or $300, whichever is lower. Exceptions may be made for special models or modifications.

(g) Payments for nurse midwife services shall be limited to seventy-five per cent of the Medicaid reimbursement rate for obstetricians and gynecologists.

(h) Payments to pediatric nurse practitioners and family nurse practitioners shall be limited to seventy-five per cent of the prevailing customary Medicaid allowance for pediatric physicians and family practice physicians.

(i) Payments for clinic services (other than physician-based clinics) shall be limited to rates established by the department. The types of clinics include government sponsored non-profit, and hospital-based clinics.

(j) Payments for teaching physicians shall be limited to rates established by the department. Payments are made to the teaching hospital, not to the physician, and per visit payment of $24.

(k) Payment for medical supplies shall be the lowest of billed charges, the rate established by the department, or the Medicare fee schedule for providers who participate in Medicare.

(l) Payments for home pharmacy services shall be the lower of billed charges, the rate established by the department or the Medicare fee schedule for providers who participate in Medicare.

(m) Payments for sleep services shall be the lower of billed charges, the rate established by the department or the Medicare fee schedule for providers who participate in Medicare.

(n) Payments for targeted case management services:

1. Payment is based on negotiated rates which take into consideration Medicaid allowable costs.

   The State has a system in place to accumulate claim costs for the services. Rates are reassessed annually based on historical information provided by the Department of Health and verified by the Department of Human Services. Historical data will be used to set the base each year and any new add-ons will be calculated into the new rate.

   A. Services shall be reimbursable only for calendar months during which at least one face to face or telephone contact is made with the recipient or collaterals.

   B. Payments shall not be made for services for which another payer is liable, nor for services for which no payment liability has incurred.

C. Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

D. Requests for payments shall be submitted on a form specified by the Department and shall include the:

(i) Date of service;

(ii) Recipient's name and identification number;

(iii) Name of the provider and person who provided the service;

(iv) Nature, procedure code, units of service; and

(v) Place of service.

2. Payments for Medicaid recipients, who are medically-fragile, are based on negotiated rates. The negotiated rates are based on cost data submitted by each provider agency which take into consideration allowable Medicaid cost, expenditures related to case management services, and administrative expenditures. These costs will serve as the basis from which the final rate will be negotiated. Negotiation of the rate will take into consideration items such as but not limited to type of existing services, new add-on services, and area availability.

Negotiated rates will be re-calculated by the Department of Human Services each year using the last full year of available data.

A. Payments shall not be made for services for which another payer is liable, nor for services for which no payment liability has incurred.

B. Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

C. Requests for payments shall be submitted on a form specified by the Department and shall include:

(i) Date of Service;

(ii) Recipient's name and identification number;

(iii) Name of the provider and person who provided the service;

(iv) Nature, procedure code, units of service; and;

(v) Place of service.

3. Payments shall be limited to agencies that are authorized Medicaid providers for the following case management services:

A. Case Management – Inpatient hospital for ventilator dependent/tracheostomized child prior to initial discharge to home/community - requires authorization.

B. Case Management for ventilator dependent/tracheostomized child living in the home/community – requires authorization.

C. Case Management for non-ventilator dependent/non tracheostomized child with significant medical needs – requires authorization.

D. Maintenance Case Management for children with significant medical needs whose caregivers are able to access services and supplies with little assistance from case managers – requires authorization.

E. Additional case management hours to address changing medical needs – requires authorization and a report.

(o) Effective July 1, 2001, the Department will adopt the following statewide, fee-for-service reimbursement rates for each community mental service:

SERVICE	PROVIDER TYPE	UNITS OF SERVICE	REIMBURSEMENT METHODOLOGY
Crisis management: 1. Telephone contact	Agency	Per contact	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
2. Telephone contact followed by face to face	Agency	Per contact	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare.

2. Telephone contact followed by face to face (continued)			• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Crisis residential	Agency	Daily	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Biopsychosocial rehab	Agency	Billed in 15 minute increments.	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule

Biopsychosocial rehab (continued)			• Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability.
Intensive family intervention	Agency	Billed in 15 minute increments.	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Therapeutic supports	Agency	Daily	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the

Therapeutic supports (continued)			established fee schedule • Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Intensive outpatient hospital services	Agency	Daily	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
ACT	Agency	Billed in 15 minute increments.	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule

ACT (continued)			• Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability

(p) Payments to a facility for non-emergency care rendered in an emergency room shall not exceed:

1. The rate negotiated by the Department;

2. Seventy-five per cent of billed charges; or

3. The Medicare fee schedule for providers participating in Medicare.

The payment to an emergency room physician for the screening and assessment of a patient who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straightforward medical decision making.

(q) The upper limits on payments for all noninstitutional items and services shall be established by the department in accordance with section 346-59, HRS, and other applicable state statutes.

4. PAYMENT FOR CERTAIN OTHER NON-INSTITUTIONAL ITEMS AND SERVICES:

a. Payment for prescribed drugs:

1. For single source drugs, shall not exceed the lower of:

A. The billed charged;

B. The providers' usual and customary charge to the general public; or

C. The estimated acquisition cost (EAC) or the average